STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE SECOND ASSESSMENT YEAR	)	DECISION AND ORDER
Docket No. INS-06-900	)	

Superintendent of Insurance Alessandro A. Iuppa issues the following Decision and Order in this matter.

I. BACKGROUND

A. The Law

This adjudicatory proceeding was conducted by the Superintendent pursuant to 24-A M.R.S.A. § 6913(1)(C); the Maine Administrative Procedure Act, 5 M.R.S.A. chapter 375, subchapter 4; 24-A M.R.S.A. §§ 229 to 236; Bureau of Insurance Rule Chapter 350; and orders of the Superintendent in this matter.

On May 12, 2006, pursuant to 24-A M.R.S.A. § 6913(1)(A), the Board of Directors of the Dirigo Health Agency (the "Board" or "Dirigo")[1] made its annual determination of:

> The aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

The purpose of this proceeding and hearing is for the Superintendent to review the Dirigo filing and "issue an order approving, in whole or in part, or disapproving the [Dirigo] filing". 24-A M.R.S.A. § 6913(1)(C). The Superintendent is required to "approve the filing upon a determination that the aggregate measurable cost savings filed by the board are reasonably supported by the evidence in the record." *Id*. Dirigo, as the moving party, has the burden of proving that its determination of aggregate measurable cost savings is reasonably supported by the evidence in the record.

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[1] The seven members of the Dirigo Board are: Robert McAfee, M.D., Chair, former President of the American Medical Association; Dana Connors, President, Maine State Chamber of Commerce; Jonathan Beal, Esq.; Ned McCann, Secretary-Treasurer, Maine AFL-CIO; Trish Riley *ex officio*, Director of the Governor's Office of Health Policy & Finance; Rebecca Wyke *ex officio*, Commissioner of the Maine Department of Administrative & Financial Services; and Lloyd LaFountain *ex officio*, Acting Commissioner of the Maine Department of Professional & Financial Regulation. The *ex officio* Board members do not have voting power. The full complement of Board members is eight, but one of the five voting positions is vacant at this time.

The Superintendent previously interpreted "reasonably supported by the evidence" to refer to the totality of the evidence and not to any part of the evidence taken out of context. Decision and Order for the First Assessment Year, Docket No. INS-05-700 (the "year one Decision") at page 2. Furthermore, the Superintendent has stated that "reasonably supported" is not equivalent to a preponderance-of-the-evidence standard. *Id*. Dirigo does not have to prove that its chosen alternative is the best or only alternative supported by the record, nor does it have to show that its chosen alternative is the most reasonable, but rather Dirigo must show that the evidence in the record reasonably supports its alternative. *Id.*

II. PARTIES

The Dirigo Health Agency, through its Board of Directors, is a party to the proceeding. Other parties to the proceeding, pursuant to grants of intervention, include the Maine Automobile Dealers Association Insurance Trust, the Maine Association of Health Plans, Anthem Health Plans of Maine, Inc. d/b/a/ Anthem Blue Cross and Blue Shield, Consumers for Affordable Health Care, and the Maine State Chamber of Commerce.

Maine Automobile Dealers Association Insurance Trust (the "Trust"). The Trust is a multiple employer welfare arrangement (MEWA) that secures health insurance for approximately 3,200 employee participants and 5,800 insurable lives. The Trust asserted that it employs a third-party administrator (TPA) to manage and administer its health insurance programs. Under 24-A M.R.S.A. §§ 6913(2) and 6913(3), TPAs are subject to savings offset payments that could result from an approval in this proceeding of Dirigo Health's determination of aggregate measurable cost savings. The Trust further asserted that any such savings offset payments will be passed on by the TPA to the Trust and, therefore, that the Trust, its members, and their participants will incur higher health insurance costs thereby making them substantially and directly affected by this proceeding.

The Maine Association of Health Plans ("MEAHP"). MEAHP is an incorporated association of health plans whose members are entities licensed by the Superintendent, including health insurers, health maintenance organizations, and TPAs.[2] MEAHP asserted that pursuant to 24-A M.R.S.A. §§ 6913(2), 6913(3), and 6915 each of its members is required to pay savings offset payments which may be approved in this proceeding. MEAHP further asserted that the imposition of the assessment of the savings offset payment on paid claims of customers of MEAHP's member companies will necessitate an increase in prices charged by MEAHP's members to customers and potential customers and may result in loss of business due to such an increase. MEAHP argued, therefore, that each of its members is substantially and directly affected by the proceeding.

Anthem Health Plans of Maine, Inc. d/b/a/ Anthem Blue Cross and Blue Shield ("Anthem"). Anthem is a licensed health insurance carrier in Maine as well as the current administrator of the DirigoChoice program. It asserted that the savings offset payment under review in this proceeding must be paid in the first instance by, among others, health insurance carriers. It further asserted that Anthem member premium rates will be affected by the amount

[2] MEAHP identifies in its application as one of its members Anthem Blue Cross and Blue Shield of Maine which was also granted intervenor status in this proceeding.

of the savings offset payment as it is used in calculating Anthem member rates. Finally, Anthem asserted that it is one of the State's largest employers and will bear the burden of paying the savings offset payment in its own premium rates for its employee group. Anthem argued, therefore, that it has a substantial and direct interest in the proceeding.

Maine State Chamber of Commerce (the "Chamber"). The Chamber is a statewide business association representing large and small Maine businesses. Its members include businesses that provide health coverage for their employees through self-funded plans and insured plans, and the Chamber itself has an insured plan for its own employees. The Chamber asserted that any aggregate measurable cost savings found reasonably supported by the Superintendent will be used to determine the savings offset payment to be assessed against health insurance carriers, employee benefit excess insurance carriers, and TPAs and, therefore, will have a tremendous impact on Maine's business community because every employer in Maine that provides health care coverage to its employees (whether self-funded or insured) will be affected. Although the savings offset payment will be paid directly by health insurance carriers, TPAs, and employee excess benefit insurance carriers, the Chamber further asserted that it is Maine employers and their employees that ultimately will pay the savings offset payment because carriers will have the ability to pass the savings offset payment on to employers in their premium rates and TPAs will have the ability to pass the assessment on to self-funded plans directly. The Chamber asserted that on these grounds it has a substantial and direct interest in the proceeding.

Consumers for Affordable Health Care ("CAHC"). CAHC is the State's largest consumer health coalition whose mission is to advocate for affordable, quality health care. Its membership of over 100 entities, including 35 businesses and organizations, collectively represents the health care and coverage interests of over 200,000 Maine citizens. CAHC asserted that its members include (i) purchasers of health insurance coverage, including DirigoChoice, and (ii) insured and underinsured individuals and small businesses, and publicly insured individuals and families, in need of affordable coverage under DirigoChoice; and that these members' health insurance rates, subsidies, and/or coverage may be affected by this proceeding.

III. PROCEDURAL HISTORY

The Dirigo filing includes supporting materials in the form of the administrative record generated in the proceeding before Dirigo. This administrative record numbers over 5,000 pages and has been made available for public inspection at the offices of the Bureau of Insurance in Gardiner, Maine throughout this proceeding. All other filings made by the parties and the Superintendent's interlocutory rulings and orders have been posted throughout the proceeding to the Bureau's web page at www.maineinsurancereg.org for public access and inspection.

On April 26, 2006, the Superintendent issued a Notice of Pending Proceeding and Hearing, among other matters setting the intervention deadline and contingent hearing dates. The April 26th Order also included initial procedures for the conduct of the proceeding.

On June 9, 2006, the Dirigo Board, through its counsel, Assistant Attorney General William Laubenstein, submitted the Dirigo filing. The Dirigo filing consists of the Board's June 6, 2006, written Decision and a certified copy of the complete administrative record of the

proceeding before Dirigo, In Re: Determination of Aggregate Measurable Cost Savings for the Second Assessment Year (2007). A correction to the filing was made by Dirigo on June 12, 2006, to identify the total aggregate measurable cost savings amount as $41,757,000.

Intervention applications were granted by Order on Intervention and Procedures, dated June 15, 2006, for the Trust represented by Bruce Gerrity, Esq., MEAHP represented by Michael Frink, Esq., Anthem represented by Christopher Roach, Esq., the Chamber represented by William Stiles, Esq., and CAHC represented by Joseph Ditré, Esq. The June 15th Order also included further procedures for the conduct of the proceeding in addition to those set forth in the April 26th Order.

On June 19, 2006, Dirigo filed a motion for leave to present additional evidence; CAHC moved for leave to serve informational requests and/or present additional evidence; Anthem sought a reservation with respect to informational requests and presentation of additional evidence, and requested an enlargement of the deadline to file reply briefs. On June 21, 2006, MEAHP filed a motion in support of Anthem's request for an enlargement and also requested a reservation of rights related to any introduction of new evidence or the offer of additional testimony. Also on June 21st, Anthem, MEAHP, the Trust, and the Chamber filed separate motions in opposition to presenting additional evidence. CAHC filed a consolidated reply to the oppositions on June 23rd. By Order on Motions, dated June 26, 2006, the Superintendent granted an enlargement of time to file reply briefs, denied Dirigo's and CAHC's motions regarding discovery and additional evidence, and dismissed as moot Anthem's and MEAHP's reservation of rights regarding additional evidence.

On June 23, 2006, all intervenor parties filed separate briefs.

On June 28, 2006, a joint letter was filed concerning affiliations of a Dirigo Board member. By filing made June 30th, CAHC requested remand to the Board for the taking of additional evidence on outstanding issues of law and fact. A joint response to CAHC was filed on June 30th. The Superintendent denied CAHC's request by Order on Request for Remand, dated July 6, 2006.

On June 30, 2006, the Superintendent issued a Scheduling Order setting forth the procedure for oral argument at hearing and the order of issues to be addressed at the hearing. Dirigo filed its brief on June 30th and separately moved for reconsideration of the Superintendent's June 26th Order denying the motion for leave to present additional evidence. MEAHP filed an opposition to Dirigo's motion. The Superintendent denied Dirigo's motion by Order on Dirigo Motion for Reconsideration, dated July 5, 2006.

On July 7, 2006, all intervenor parties filed separate reply briefs. Also on July 7th, the Superintendent issued an Order Regarding the Record in which the Superintendent (a) directed Dirigo to provide a copy of the electronic operational form of certain spreadsheets of which the record transmitted to the Superintendent contained hard-copy reproductions (paper versions); and (b) ruled that certain documentary evidence appended to CAHC's brief as Exhibits 3 and 4 was irrelevant and not admissible in this proceeding. That same day, July 7th, Dirigo filed electronic copies of the requested spreadsheets with the Superintendent. On July 11, 2006, Dirigo filed a response to the Superintendent's July 7th Order.

On July 10, 2006, CAHC moved to amend the Scheduling Order issued by the Superintendent on June 30, 2006. The Superintendent denied CAHC's motion by Order on Motion to Amend Scheduling Order, dated July 11, 2006.

The hearing was held in Augusta, Maine on July 12, 2006. The hearing was conducted entirely in public session. The hearing also was "web cast" over the Internet. In response to an oral motion made by Anthem, the Superintendent ruled that the portion of CAHC's reply brief that contained information previously ruled by the Superintendent as irrelevant and inadmissible would be treated as such. Counsel for each of the parties presented oral argument at the hearing. At the conclusion of the hearing, the Superintendent memorialized in writing a document entitled Hearing Questions for Citations to the Record, dated July 12, 2006, and established a deadline of July 14, 2006, for responsive filings by the parties. Dirigo made a filing on July 14th as did intervenors Anthem, MEAHP, the Trust, and the Chamber (jointly).

IV. DISCUSSION, ANALYSIS, FINDINGS, AND CONCLUSIONS

The Dirigo filing attributes aggregate measurable cost savings to four savings initiatives. The table below identifies the initiatives, the amount of savings approved by Dirigo as contained in its filing, and the amount of savings for each initiative that the Superintendent hereby deems reasonably supported by the evidence in the record.

SAVINGS INITIATIVES	DIRIGO FILING	AMOUNT DEEMED REASONABLY SUPPORTED
Hospital Savings Initiatives	$14.5 million	$14.5 million
Uninsured Savings Initiatives	$6.7 million	$5.5 million
Certificate of Need and Capital Investment Fund Savings Initiatives	$5.4 million	none
Health Care Provider Fee Savings Initiatives	$15.2 million	$14.3 million
TOTAL	$41.8 million	$34.3 million

A. Legal Issues Raised by the Parties

The Superintendent's statutory responsibility in this proceeding is limited to determining whether the "aggregate measurable cost savings filed by the board are reasonably supported by the evidence in the record." 24-A M.R.S.A. § 6913(1)(C). In making this decision, the Superintendent has the authority to "issue an order approving, in whole or in part, or disapproving the filing." *Id*.

In addition to the factual issues surrounding the reasonableness of Dirigo's determination of aggregate measurable cost savings, intervenors opposing the filing have argued that several elements of cost savings presented by Dirigo do not fit the statutory description of "aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs

to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. § 6913(1)(A). As was decided by the Superintendent in his year one Decision, the statutory interpretations made by the Dirigo Board regarding execution of 24-A M.R.S.A. §§ 6913(1)(A) & (B) which it administers in making its determination of aggregate measurable cost savings will not be reviewed or disturbed by the Superintendent as those issues are beyond the jurisdiction conferred upon the Superintendent by the Legislature in 24-A M.R.S.A. § 6913(1)(C). Furthermore, this interpretation is currently on appeal by several of the intervenors to the Maine courts. *See* Maine Association of Health Plans, et al. v. Superintendent of Insurance, Superior Court, Cumberland County, Docket No. AP-05-90 (95/96) (consolidated appeals of the Superintendent's year one Decision). Several of the intervenors also have filed appeals in Superior Court of Dirigo's year two aggregate measurable cost savings determination. For the foregoing reasons, the Superintendent again declines to review issues beyond his statutory jurisdiction.

Certain intervenors also have asserted a variety of procedural defects or irregularities which they allege cast doubt on the reasonableness of the determination made by Dirigo. However, the Superintendent has not been granted the power by the Legislature, as was acknowledged in at least one motion, to provide relief to parties who are aggrieved by such defects or irregularities. Instead, the Superintendent is tasked with a review of the evidence in the record to determine if that evidence reasonably supports the filing made by Dirigo. This limited jurisdiction over the determination made by Dirigo does not invest the Superintendent with the powers of the judicial branch, in this instance to rule on the legality of substantive and procedural decisions made by Dirigo, a separate executive agency, under its separate statutory responsibilities.

B. Dirigo's Determination of Aggregate Measurable Cost Savings

To assist it in developing a methodology for calculating aggregate measurable cost savings, Dirigo retained the consulting firm of Mercer Government Human Services Consulting ("Mercer"). Mercer's undertaking culminated in a document entitled Dirigo Health Savings Offset Payment: Year 2 – Methodology and Data Sources (Dirigo record at pages 1397-1435, hereinafter "R. at ___"), as supplemented by a document entitled Dirigo Health Savings Offset Payment: Year 2 – Methodology Update and Preliminary Calculations (R. at 1436-1464) (collectively, the "Mercer Report"). Mercer determined the savings from all Dirigo initiatives to total $100 million. (R. at 1439.) The Board adopted all of Mercer's savings initiative categories, but modified one aspect of the hospital initiative calculation, thereby adopting a savings amount of $41.8 million.[3]

One global issue that must be addressed before discussing each of the separate savings initiatives is the appropriate time period or periods for which savings are to be measured. The record reflects that Mercer interpreted the Superintendent's year one Decision to require that all

[3] The Board rejected Mercer's use of the geometric mean rate of growth and instead used a median rate of growth over the same period in the hospital savings calculation, thereby reducing Mercer's estimated hospital savings amount from $72.7 million to $14.5 million.

savings be measured for a uniform time period.[4] This is not the case. The year one Decision did not find it reasonably supported to reflect different time periods within a single formula in connection with a single component of cost savings (Decision, page 12), but one cannot infer anything from this about the appropriateness of using different time periods for different components. In fact, different time periods were used for different components in year one, and the Superintendent did not find this unreasonable. Inclusion of savings from time periods beyond the end of the then current calendar year were, however, found by the Superintendent in year one not to be reasonably supported by the evidence in the record. (Decision, page 16.) One other principle should be noted with regard to time periods. The savings for a given initiative should not reflect a time period longer than 12 months. This was not addressed in the year one Decision since the only initiative where a longer period was used (CON/CIF) was found not to be reasonably supported on other grounds.

1. Hospital Savings Initiatives ("CMAD"). (*See* R. at 1410-1415, 1440-1442.) Dirigo Determination: $14.5 million. Amount deemed reasonably supported: $14.5 million.

The hospital savings initiative component of Dirigo's filing seeks to measure reductions in the cost of inpatient and outpatient services provided by hospitals and their subsidiaries. Reducing the rate of increase in the cost of services reduces the need for commercial payor rate increases and results in savings to the entire health care system. Mercer has measured these savings in terms of average cost per patient, or more precisely, in terms of average cost per hospital stay (counted at the time of discharge), as adjusted for the hospital's case mix, hence the abbreviation "CMAD" (case-mix-adjusted discharge). The savings across hospitals and their subsidiaries were determined by Mercer to be $72.7 million for state fiscal year (SFY) 2005, including interest adjustment to calendar year (CY) 2006. (R. at 1453.) The Dirigo Board adopted this determination in part, approving $14.5 million.

Mercer explains that it has attempted to address the issues raised in the Superintendent's year one Decision by performing the cost-per-CMAD savings calculation at the aggregate level, across all Maine hospitals, rather than summing hospital-specific calculations. The methodology employed was essentially unchanged from year one, except for the aggregation. (R. at 213-217, 1081-1083, 1106-1164.) Costs per case-mix-adjusted discharge were calculated for years 2000-2005 across all hospitals. The actual 2005 CMAD was compared to a 2005 projected CMAD estimated from the 2003 CMAD inflated by the degree to which the CMAD growth exceeded the Hospital Market Basket Index historically. The same Medicare cost report data used in year one was utilized, with the addition of 2005 data. For the year two calculation, discharge and case-mix data were obtained from the Maine Health Data Organization.

Intervenors raised a number of objections to Mercer's CMAD calculation, the implications of which would reduce or eliminate any aggregate measurable cost savings associated with CMAD. These objections were raised during the hearing before the Dirigo Board, and were considered by the Board in reducing the savings estimate from the $72.7 million

[4] For example, in discussing the year two methodology for CMAD, Mr. Schramm of Mercer testified, "Finally, to address a concern raised by the Superintendent, about determining savings across inconsistent time periods, Mercer will apply an interest factor to adjust the savings to a consistent present value." (R. at 1270.)

proposed by Mercer to the $14.5 million adopted by the Board. The Superintendent's review of the record includes consideration of the Mercer Report, the debate about the objections raised by the intervenors, and the Board's consideration of these objections in reducing the estimate to $14.5 million, as well as subsequent arguments made before and during the Superintendent's hearing. In reviewing the Dirigo filing, the Superintendent is charged with determining whether the Board's determination, based as it was on consideration of the proposed methodology and the intervenors' objections, and its resulting reduction of the savings estimate from $72.7 million, produced an estimate that is reasonably supported by the evidence in the record.

Intervenors observed that the cost growth of 6.8% during 2005 exceeded the historical baseline (2000-2003) cost growth of 6.0% and was triple the 2004 cost growth of 1.9%, and argued that as a result there could be no savings during 2005. While this objection accurately describes the cost growth rates during these years, it does not consider the effect that the lowered 2004 cost growth has on subsequent years. Lowered 2004 cost growth effectively lowers the cost in later years; for example, if costs in 2003 were $100 and grew at the actual rates for 2004 and 2005 of 1.9% and 6.9%, they would be $108.93 in 2005, which is 3% lower than the $112.36 that would have resulted if costs had increased in both years at the average historical growth rate of 6.0%. This effect does not, as was argued, double-count 2004 savings, but rather considers the continuing effects on 2005 spending levels of the same cost containment efforts that had produced the reduction in 2004 spending levels. An average (and up to a point, even an above-average) growth rate applied to a lowered cost base produces a lower cost level than would have occurred otherwise. Using a baseline cost of $1.868 billion in 2003 applied to the numbers above (without adjusting for actual inflation with Hospital Market Basket Index) would produce an estimate of lower spending of $66 million. However, consideration of other issues discussed below would reduce this figure.

It was also argued that the historical baseline-period cost growth rate was too high and was driven by an anomalously high growth rate of 10.1% in 2002. The Dirigo Board specifically considered this issue and cited it as an important consideration in reducing the CMAD-related savings estimate. The $14.5 million savings estimate adopted by the Board resulted from a calculation that replaced the actual observed growth over the baseline period, annualized by taking the geometric mean, as proposed by Mercer, with the median annual rate of growth over the same period. This reduced the growth rate used from 6.9% to 4.7%. Dirigo attributed this decision to consideration of the baseline rate of growth that results when the 2002 growth rate is left in the base, and to other issues that were raised about the CMAD estimate. The use of the median as a measure of central tendency is sometimes desirable when data contains outlier values, such as those in 2002. However, the median may be a poorer measure of central tendency when measured from only three data points. In this instance, evidence in the record supports the conclusion that use of the median likely represents a conservatively low choice for the calculation. As noted by the Board in its deliberations and discussed here, the choice of the median rather than the mean produces a lower number, and this conservatism offsets (and was intended by the Board to offset) several other issues raised by the intervenors.

Similarly, intervenors argued that inclusion of one additional year in the baseline (1999) would eliminate all savings. However, the record does not contain the 1999 data elements for hospital-specific costs and discharges required to evaluate this assertion. Intervenors further argued that the CMAD measure is overly sensitive to swings in hospital volume and that the

results of the CMAD-related savings were due to random variations in year-to-year volume. However, aggregate cost data computable from evidence in the record display a pattern which would support savings estimates as least as high as those derived from volume-adjusted (CMAD) costs. (*See* R. at 1112-1159.)

Intervenors objected to the exclusion of the hospital tax from the calculations of hospital expense, asserting that these were valid expenses reflected in the financial statements of the organizations. Dirigo asserts in its reply brief that these costs are not excluded, but it is clear from the worksheets on the record that they are in fact excluded in the calculations. In that this expense largely nets to zero with respect to the hospitals' incomes, it would not impact the pricing hospitals set for commercial payors. Evidence was introduced by the Chamber indicating that there was a net cost to hospitals of approximately $5 million due to the tax. However, the tax was not levied for most of the base period, so that including it in the observed costs would introduce a distortion in the evaluation of cost growth over time.

It was pointed out by intervenors that commercially insured patients represent only one part of hospitals' service load, and that Medicare and Medicaid are government programs with a large share of hospitals' costs. Two arguments were advanced related to this point. First, that any savings should be pro-rated to reflect the portion of the hospitals' activity related to commercially insured patients. This argument is unpersuasive because it ignores the fact that, to the extent that payments from government payors are fixed, any decrease in costs could be available in full for reduction of prices for commercially insured patients. A second, more focused argument is that government payments are not completely fixed, because some components of government reimbursement are cost-based, and thus would be reduced as costs are reduced. This revenue loss makes a portion of the savings unavailable for price relief to commercial payors. The evidence in the record indicates that these components are (i) all Medicare and Medicaid costs for critical access hospitals, and (ii) Medicaid hospital outpatient costs in non-critical access hospitals. The second argument is more persuasive and suggests that a reduction to the savings estimate should be made to adjust for those cost savings that result in corresponding revenue reductions. This adjustment would in any case be covered by the reduction made by the Dirigo Board to the savings estimate from $72.7 million to $14.5 million.

Mercer's spreadsheets related to CMAD savings indicate that Maine critical access hospitals account for 13.7% of hospital costs in 2005. No evidence is available in the record to indicate what proportion of cost is accounted for by Medicaid outpatient costs for non-critical access hospitals. Calculation of this proportion would begin with 86.3% of costs for non-critical access hospitals, and then be reduced twice, once for the percentage of Medicaid activity and once for the fraction of that activity which is outpatient activity. While it is not possible to calculate this percentage from the evidence in the record, if Medicaid were 25% of costs for non-critical access hospitals and outpatient were 50% of Medicaid cost in these hospitals, this would represent approximately an additional 11% of costs over and above the 13.7% for critical access hospitals. In total, it would appear unlikely that these cost-reimbursed sectors of hospital payment exceed 25% of hospital costs. If this fraction of cost were known, a reduction of the savings estimate for that fraction would be appropriate. In this year's CMAD cost savings determination this fraction of cost would in any case be covered by the reduction made by the Dirigo Board to the savings estimate from $72.7 million to $14.5 million.

Intervenors also provided evidence that MaineCare implemented cuts in Medicaid payments that affected hospital revenues during the evaluation period, and suggested that hospitals would reduce costs in response. Following the logic advanced by the intervenors, as described in the preceding section, such cuts would not be expected to be carried out by critical access hospitals, as cuts in revenue on par with reductions in cost would result. For non-critical access hospitals, some fraction of the reduced costs would be lost in reimbursement for MaineCare outpatient costs. In any case, there is no evidence in the record to indicate the degree to which hospitals would respond with cost reductions as opposed to price increases.

Overall, the Superintendent agrees with the Dirigo Board that there are valid criticisms of Mercer's estimated hospital savings of $72.7 million, and that the reduction to $14.5 million adopted by Dirigo sufficiently redresses the potential impacts of the issues raised in these criticisms. Accordingly, Dirigo's determination of $14.5 million in hospital savings is found by the Superintendent to be reasonably supported by the evidence in the record. (*See* R. at 213-217, 1081-1083, 1106-1164.) In particular, the $58.2 million reduction from the Mercer estimate redresses potential inflation to the baseline cost growth due to abnormally high costs in 2002, the failure to consider potential Medicaid payment cuts, and the degree to which cost reductions produce some offsetting reduction to payments received via cost-based reimbursement for some parts of government financed care.

2. Uninsured Savings Initiatives, including reduction of uninsured bad debt and charity care, MaineCare adults expansion, and the woodwork effect. (*See* R. at 1416-1421, 1443-1444.) Dirigo Determination: $6.7 million. Amount deemed reasonably supported: $5.5 million.

The uninsured savings initiative component of Dirigo's filing seeks to measure the reduction in bad debt (BD) and charity care (CC) that results from providing health coverage to previously uninsured and underinsured individuals. As these individuals become insured through enrollment in DirigoChoice or in MaineCare through expansion of eligibility, hospitals and other health care providers will no longer incur the BD and CC costs associated with their health care and will not need to cost-shift to private payors to cover the costs of their previously non-reimbursed health care. The woodwork (WW) effect measurement refers to those MaineCare members who were previously uninsured and underinsured and came "out of the woodwork" to be enrolled in MaineCare through the Dirigo process that allocated Dirigo applicants to the correct public assistance program. The savings were determined by Mercer to be $2.7 million for BD and CC (*see* R. at 1455), $3.9 million for the MaineCare adults expansion (s*ee* R. at 1457), and $57,000 for the WW effect (s*ee* R. at 1458), for a total of $6.7 million. The Dirigo Board adopted this determination.

(a) Bad Debt & Charity Care

Mercer developed an estimate of $179 million for bad debt and charity care and attributed a portion of this to the uninsured population. Using estimates of the uninsured population, Mercer then arrived at a monthly per capita cost of bad debt of $68.88. The monthly per capita cost estimate was then adjusted to CY 2006 with a trend factor and further adjusted from charges to costs by applying a factor of .497. After applying factors for cost sharing and risk selection, the ultimate cost per previously uninsured Dirigo member was estimated to be $48.78 per

member per month (PMPM). Mercer assumed that 39% of the Dirigo enrollees would have been uninsured in the absence of Dirigo. The resulting savings estimate was derived as follows:

115,106	(projected 2006 Dirigo member months)
× .39	(portion previously uninsured)
× $48.78	(per capita monthly costs)
= $2.2 million	

With a similar process, Mercer calculated a savings estimate for previously underinsured as follows:

115,106	(projected 2006 Dirigo member months)
× .15	(portion previously underinsured)
× $29.86	(per capita monthly costs)
= $0.5 million	

As explained at page 13 of the Superintendent's year one Decision, the appropriate adjustment would have been from charges to discounted charges rather than from charges to cost. An adjustment from charges to discounted charges yields a higher ultimate cost per previously uninsured Dirigo member per month than was reached by Mercer's application of .497.

The intervenors raised a number of concerns about the Mercer methodology, including the lack of support for certain assumptions:

1. the portion of bad debt and charity care attributed to uninsured and underinsured;
2. the trend factor used to project costs to 2006;
3. the cost sharing adjustment;
4. the risk selection adjustment; and
5. the assumed percentage of Dirigo enrollment that was previously uninsured.

The intervenors asserted that Dirigo should have developed better support for several of these assumptions by utilizing existing data derived from the initial experience of the program. However, they did not offer any detailed rigorous analysis to prove their point.

Source data was referenced but not found in the record for several of Mercer's assumptions. Examples of source data not found include:

1. the survey information that was the basis for the assumption that 39% of Dirigo members were previously uninsured;
2. the source for the assumed 132,000 uninsured individuals in Maine in 2004; and
3. the adjustment for costs vs. charges, where Dirigo directed the Superintendent to review 1,460 pages of the record to discern the support for the factor used.

Accordingly, the Superintendent concludes that these three assumptions were not reasonably supported by the evidence in the record.

Several other assumptions are not well supported due to the absence of credible historic data from which to derive an unbiased estimate. The Superintendent finds that Mercer has made reasonable efforts to developed unbiased assumptions in these latter situations. For those items noted above as not reasonably supported, Dirigo should have relied on credible evidence which could have been included in the record. Nonetheless, the Superintendent finds that Dirigo's adoption of ultimate savings estimates of $2.2 million for the uninsured and $0.5 million for the underinsured is reasonably supported. The record demonstrates that any overstatement of savings due to other unsupported assumptions is more than adequately offset by the understatement of savings due to adjusting from charges to cost rather than from charges to discounted charges. Accordingly, the Superintendent finds Dirigo's determination of $2.7 million of bad debt and charity care savings to be reasonably supported by the evidence in the record.

(b) MaineCare Adults Expansion

During the measurement period there was significant growth in MaineCare due to expansions in adult eligibility. Dirigo estimated cost savings of $3.9 million from this initiative. The calculation is very similar to the calculation for the uninsured and underinsured initiatives. The following assumptions are identical to what was assumed for the uninsured initiatives:

1. average PMPM for bad debt and charity care for uninsured;
2. difference between cost and charges; and
3. cost sharing adjustments.

Mercer calculated a savings estimate due to the MaineCare adults expansion as follows:

80,315	(projected MaineCare enrollment, July 2005 – December 2006)
× 1.00	(100% assumed previously uninsured)
× $48.35	(per capita monthly costs)
= $3.9 million	

The Superintendent finds that several of Mercer's assumptions are not reasonably supported. First, as stated above, using a period longer than twelve months by assessing savings in both CY 2005 and CY 2006 is not reasonably supported. CY 2005 enrollment should not be included. Those savings should have been identified and considered along with the other savings in Dirigo's year one determination. Because the method by which payors recapture cost savings from providers is a reduction in the unit cost of services, it is not reasonable to assume that a year and a half of savings could be recaptured during a single year.

Also, the Superintendent does not find the assumption that 100% of the new MaineCare enrollment was previously uninsured to be reasonable. There is evidence in the record of a negative impact on enrollment in other insurance plans when Medicaid eligibility is expanded. (*See* R. at 3718-3722.) Given the difficulty that those eligible for MaineCare would likely have paying for private coverage and given the lack of evidence in the record to enable quantification of the appropriate reduction, it would not be unreasonable to assume that the proportion previously insured is small but not zero, especially in light of Mercer's treatment of a $57,000

woodwork effect as material. Those few new MaineCare enrollees who were previously insured would slightly reduce the number of previously uninsured people who account for the reduction in BD/CC. In addition to this reduction in the calculated savings, MaineCare would reimburse at a lower level than the commercial coverage those individuals had previously, thereby further reducing the amount of savings as a result of MaineCare enrollment. This leads to a negative woodwork effect. The Superintendent was clear in his year one Decision that it was not reasonable for Mercer to count positive outcomes and ignore negative outcomes. However, the absence of the small reduction to the calculated savings and the small negative woodwork effect are not enough to warrant disapproving the entire savings for the MaineCare expansion. The resulting small overstatement of the savings in this category is offset by the understatement of bad debt and charity care savings noted in (a) above and by the disapproval of the woodwork effect savings discussed in (c) below.

The factor .497, although not reasonably supported by the evidence for uninsured and underinsured initiatives, is reasonably supported by the evidence for the MaineCare adults expansion initiative. The factor .497 is reasonably supported by the expectation that discounts from charges will be much greater for a Medicaid subscriber than for a Dirigo subscriber.

The Superintendent finds reasonably supported the savings amount calculated by Mercer for CY 2006 only. This amount is derived by eliminating the 2005 enrollment from the calculation of savings and then adjusting the trending factor of 8.3% to 9.2% to reflect the different projection period. Accordingly, the Superintendent finds part of the MaineCare adults expansion savings determined by Dirigo to be reasonably supported by the evidence in the record, and approves the Board's filing on this initiative in part, for a total of $2.8 million.

(c) The Woodwork Effect

Mercer estimated the incremental enrollment in MaineCare due to Dirigo by taking credit only for 76 individuals who specifically applied for Dirigo coverage, but were instead enrolled in MaineCare based on eligibility. Other factors and assumptions were the same as for the MaineCare adults expansion. The Superintendent finds this approach to be reasonable with two exceptions. First, Dirigo may not take credit for enrollment during CY 2005, for the same reasons outlined in the discussion of savings due to the MaineCare adults expansion. Eliminating the 2005 enrollment and adjusting the trend factor to 9.2% because of the different projection period would reduce the savings from $57,000 to $43,000. Second, as with the MaineCare adults expansion, it is not reasonable to assume that 100% of those who enrolled in MaineCare due to the woodwork effect were previously uninsured. As discussed above, there should be a small reduction to the calculated savings as well as a small adjustment for the negative woodwork effect. Here again, there is no evidence in the record to enable quantification of these adjustments. In light of the small amount of woodwork effect savings and the small overstatement of MaineCare adults expansion savings discussed above, the Superintendent finds that it is not reasonable to allow any recognition of these savings. The Superintendent therefore finds that Dirigo's determination of $57,000 in woodwork effect savings not to be reasonably supported by the evidence in the record and disapproves the entire amount of the estimated woodwork effect.

3. Certificate of Need and Capital Investment Fund Savings Initiatives. (*See* R. at 1422-1424, 1445-1447.) Dirigo Determination: $5.4 million. Amount deemed reasonably supported: none.

The certificate of need and capital investment fund savings initiative component of Dirigo's filing seeks to measure the effect of reductions in major capital spending projects for hospital and non-hospital providers. As this spending is reduced, the need for payor rate increases is reduced. Mercer explains that these savings result from modifications made by the State to the criteria for Certificates of Need (CON) and the imposition of a limit on all new spending to an annually adjusted amount within the Capital Investment Fund (CIF). The savings were determined by Mercer to be $4 million for withdrawn CON applications (*see* R. at 1460) and $1.4 million for large hospital projects not approved in CY 2006, for a total of $5.4 million (*see* R. at 1461). The Dirigo Board adopted this determination.

It is undisputed that the CON/CIF savings consist entirely of reductions in hospital costs of the type that are already reflected in the "cost-per-CMAD" savings calculation. The costs for projects identified in Dirigo's savings estimates are for future periods and would appear in CMAD calculations for those periods. Dirigo concedes the redundancy between the CON/CIF initiatives and the hospital savings initiatives, but has adopted Mercer's recommendation to recognize CON/CIF savings at present value in the year in which the project would have been approved, with the understanding that adjustments would have to be made in future years to the cost-per-CMAD savings in order to correct for the double-counting. It is appropriate to evaluate whether savings have been realized by comparing project present values organized by year of approval. However, recognition of cost savings should occur in the year costs are actually incurred. The Mercer approach adopted by the Dirigo Board would produce the unreasonable result that savings would be counted before they are realized, and would then have to be subtracted from the period in which they were realized. However, as noted above, an approach in which costs are recognized in the year of incurral produces redundancy with the CMAD savings calculation.

Because of this redundancy, it is not reasonable to recognize CON/CIF as a separate category of savings. The adjustments proposed, like Ptolemaic epicycles, make the calculation of savings needlessly complex and serve only to obscure what is really happening. The record does not show any purpose for treating CON/CIF as a separate category of savings other than the desire to accelerate the recognition of these savings before they actually flow through to the cost per CMAD. When asked by the Superintendent at hearing and in the written hearing questions if there was any evidence in the record that CON savings could be realized by payors in a year before the savings are actually realized by the hospitals and thus captured in the CMAD calculation, Dirigo acknowledged that there was none.

The Superintendent therefore concludes that it is not reasonably supported by the evidence in the record to recognize any savings from the CON/CIF initiatives except to the extent that they appear in the hospital savings initiatives calculations during the years the savings are actually realized, and therefore concludes further that it is not appropriate to include this category as a separate line item.

4. Health Care Provider Fee Savings Initiatives, including hospital fee initiatives and physician fee initiatives. (*See* R. at 1425-1427, 1448.) Dirigo Determination: $15.2 million. Amount deemed reasonably supported: $14.3 million.

Mercer explains that hospitals and other health care providers meet their annual financial requirements using a variety of funding sources. Over the long term, differences between financial requirements and payments by various payors may be shifted to private sector payors, whose rates are negotiable (unlike the public sector – Medicare and Medicaid – where rates are determined by the public payors), resulting in higher rate increases to private payors. The State will make additional payments to hospitals and physicians as a result of the Dirigo Health Reform Act and its related initiatives, to recognize differences identified by the Maine Hospital Commission in its review of the funding of the Medicaid program. Thus, the need for cost increases to other payors will be reduced when this additional cash is received by hospitals and physician providers, resulting in savings to the health care system. The savings were determined by Mercer to be $7.0 million for hospital prospective interim payment (PIP) increases and $8.2 million for physician fee increases, for a total of $15.2 million. (R. at 1463.) The Dirigo Board adopted this determination.

(a) Accelerated Prospective Interim Payments (PIP)

Mercer has estimated a savings amount of $7.0 million as the present value of interest due to early payment, in 2006, of $48,100,039 of PIP that, in the absence of Dirigo, would have been paid in 2009. The early payment amount of $48,100,039 was calculated as 50% of the early payments in the state budget for SFY 2006 and 50% of the early payments that are projected to be in the state budget for SFY 2007. The use of the 50% factor reflects the fact that 50% of these amounts in the two state budget periods can be allocated to CY 2006. The early payment amounts in these two state budget years were determined to be all amounts in excess of the baseline PIP amount of $292,414,914 in the SFY 2005 budget. Mercer then calculated the present value by accumulating this principal amount forward for three years at the relevant interest rate. Mercer determined the three-year interest rate by referring to U.S. Treasury interest rate data and projecting that recent interest rate levels would persist for the remainder of 2006. (*See* R. at 1425-1426, 1463.)

According to the pre-filed testimony of Commissioner Rebecca Wyke, all PIP increases over the baseline amount in the SFY 2005 budget were due to the Dirigo initiative and are a reasonable basis for determining a savings to hospitals. (*See* R. at 1253.) The pre-filed testimony of Steven Michaud, president of the Maine Hospital Association, contradicted this view but did not offer an alternate explanation for the increases in the PIP payments in these state budgets. (*See* R. at 4312.)

The intervenors raised several concerns about the validity of this component of aggregate measurable cost savings, including:

1. Only one year of interest should be allowed and therefore an interest amount equivalent to 14.6% of the principal amount must be too high.

2. The approach to determining the early payment amount had the effect of assuming that PIP payments, in the absence of Dirigo, would have stayed at the same level as in SFY 2005 forever.
3. Including this category results in double counting since interest expense is reflected in Medicare cost reports and therefore in CMAD.

The Superintendent finds that the determination of the early payment amount of $48,100,039 is reasonably supported by the testimonial evidence of Commissioner Wyke. The contrary testimony from Mr. Michaud provides no other explanation that would compel the Superintendent on review to find that the Board could not have relied on the Commissioner's testimony. While there may be an alternative explanation for at least some of the PIP increase, there is no analysis or quantification of any alternative explanation in the record.

The determination of this savings amount relies on the concept of the time value of money, which is a familiar and fundamental principle of finance. The Superintendent finds that reliance on this principle is reasonably supported by the evidence in the record. The payment of $48,100,039 three years early adds a value equal to the difference between that amount and the discounted value today of the payment of the same amount three years in the future. The use of a risk-free rate of return tied to rates that can be earned on U.S. Treasury investments is reasonable, in that it provides a conservative figure for the present value of the delayed reimbursements the hospitals would have received three years later in the absence of the increased PIP payments.

The Superintendent does not find the amount of interest calculated to be reasonably supported, however. There was an inappropriate change in the interest calculation formula from year one to year two. In the year one methodology, Mercer correctly compared the value of the early payments to a baseline figure obtained by discounting the future value three years back to the present. In year two, Mercer calculated the present value of the early payments themselves by accumulating the value three years into the future. This is not present value; it is future value. The year two methodology would be reasonable if Dirigo were assessing the corresponding amount three years in the future, but it is not. Given the timing of the assessment, the year one methodology is reasonable to apply to the evidence in the record. Using the year two data for early payment amounts and interest rates and the year one formula yields a savings amount of $6.1 million instead of the Mercer calculation of $7.0 million. Accordingly, the Superintendent finds part of the accelerated prospective interim payment savings determined by Dirigo to be reasonably supported by the evidence in the record, and approves the Board's filing on this initiative in part, for a total of $6.1 million.

It should be noted that this calculation is not inconsistent with the principle stated above that savings for a given initiative should not reflect a time period longer than 12 months. The increased PIP payments in question were all received during CY 2006 and the present value of a full three years of interest could be realized immediately, as illustrated in the following example. Assume the applicable interest rate is 4.3% and a hospital receives a PIP increase of $100 in 2006 rather than 2009. The hospital could invest $88.13 in a certificate of deposit paying 4.3% and redeem it for $100 in 2009, the same time it would have received the $100 without the PIP increase. This leaves the hospital with $11.87 today that it would not have had in the absence of the PIP increase. This is exactly the present value of three years of interest on $100. This

measurement, which reflects PIP increases actually paid in 2006, is in sharp contrast to the CON/CIF initiative where Mercer's methodology includes the present value of future savings that may or may not materialize but in any event have not yet occurred.

The intervenors' claims that recognizing savings from increased PIP payments double-counts cost savings would only be valid if the savings were reflected on the expense side of the ledger rather than on the revenue side. If PIP payments had not been increased, hospitals could have made up the shortfall either by dipping into surplus or other available funds or by borrowing. To the extent that they would have borrowed money and the additional PIP funds avoided the need to incur interest expense, it is possible that the avoidance of interest expense has increased CMAD savings, resulting in double counting. However, there is no evidence that hospitals would have borrowed money in the absence of the increase in PIP payments. It is quite possible that the increase simply allowed the hospitals to keep other funds invested, increasing investment income. This would not affect CMAD, so there would be no double counting.

(b) Increased Physician Payments

Mercer Exhibit H developed a savings estimate due to annual increases for physician fees of $8.2 million. (*See* R. at 1463.) In her prefiled testimony, Commissioner Wyke explained that these increased physician fee payments on behalf of Medicaid patients were attributable to the Dirigo initiative. The value of this increase in year two is the increase in payments that will be seen in CY 2006, which is $8.2 million. Mercer has measured savings of $8.2 million for year two, based on these increased physician fee payments.

The intervenors challenged the legitimacy of this category based on the fact that physicians had not received Medicaid fee increases for many years. The intervenors argue that the $8.2 million increase will be retained by physicians and not used to reduce charges to commercial payors. While it is entirely possible that physician fees to commercial payors will not be reduced because of the long-overdue Medicaid increases, it is reasonable to assume that increased revenue to physicians from the Medicaid program could reduce the need to impose even more cost-shift upon commercial payors. There is no evidence in the record that quantified other drivers besides Dirigo that impacted the $8.2 million increase in physician payments, such as volume increases due to increased enrollment or utilization. Accordingly, the Superintendent finds Dirigo's determination of $8.2 million in cost savings from physician fee increases to be reasonably supported by the evidence in the record.

C. Base Periods

There is one issue common to many of the savings initiatives discussed above. The methodologies used for nearly all of the initiatives involve a pre-Dirigo base period. A 2000-2003 base period is used for CMAD. For the uninsured initiatives, the period immediately before enrollment in Dirigo or MaineCare is, in effect, the "base period" used to determine whether an enrollee would be uninsured if not for Dirigo. For the provider fee initiatives, SFY 2005 is the base period and all increases in PIP payments or provider fees are measured from this point forward. The use of these base periods made sense for the first Dirigo year and the Superintendent finds it is reasonably supported by the evidence in the record to use them for the second year. However, the further removed the year being measured is from the base period, the

more tenuous the connection and the more questionable the assumption that all subsequent changes are related to Dirigo. Therefore, future amounts calculated from such base periods may not be reasonably supportable in future years.

V. ORDER

By reason of the foregoing, the Superintendent ORDERS that the Dirigo Board's determination of aggregate measurable cost savings is APPROVED IN PART and that $34.3 million of aggregate measurable cost savings determined by the Dirigo Board is reasonably supported by the evidence in the record.

VI. NOTICE OF APPEAL RIGHTS

This Decision and Order is final agency action of the Superintendent of Insurance within the meaning of the Maine Administrative Procedure Act. Any party may appeal this Decision and Order to the Superior Court as provided by 24-A M.R.S.A. § 236, 5 M.R.S.A. § 11001, *et seq.,* and M.R. Civ. P. 80C. Any such party must initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal within forty days after the issuance of this decision. There is no automatic stay pending appeal; application for stay may be made as provided in 5 M.R.S.A. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

Dated: July 21, 2006

ALESSANDRO A. IUPPA
Superintendent of Insurance